UNITED STATES DISTRICT COURT

DISTRICT OF NEBRASKA

HANNAH SABATA, et al.,	Case No.: 4:17-cv-03107-RFR-MDN
Plaintiffs,	
vs.	DEPOSITION TAKEN IN BEHALF OF PLAINTIFFS
NEBRASKA DEPARTMENT OF CORRECTIONAL SERVICES, et al.,	
Defendants.	

DEPOSITION OF: **DR. HARBANS DEOL**

DATE: November 30, 2018

TIME: 8:58 a.m.

PLACE: ACLU, 134 South 13th Street, Lincoln, Nebraska

regarding effective communication with patients who are either non-English speaking or deaf?

A. That's correct.

Q. How are prisoners supposed to access routine health care?

A. They can -- they can ask for it by filling out the kite, the IIR sheet that we have.

Q. I'm sorry, what was the acronym?

A. IIR.

Q. IIR, do you know what that stands for?

A. Inmate interview request.

Q. Also known as a kite?

A. Yes.

Q. So say I'm a prisoner and I have a routine non-emergency health care need and I want to request care using this process, walk me through how that would work.

A. So they would be asking for the request, the form request from staff members and the staff would provide the form. They can fill it out and put it in the box which would be picked up by medical staff and refer to those.

Q. And is the process you've just described the same process for medical, mental health and dental?

A. Yes.

Q. Now, you referred to the patient filling out the form and putting it in the box, tell me about those boxes.
A. Every housing unit has a box for the request or any kind of communication device that they would have, and they would put it in those.
Q. Is the box locked?
A. Some are, I'm not sure they all are locked or not.
Q. How long have these boxes been in existence?
A. Since I've been here, I'm not sure, with the Department of Corrections in Nebraska, I'm sure they have been there for a while.
Q. Have they been here since you -- the entire time you've been medical director?
A. Some, some units they do, some have not. And sometimes they will hand it off to director, to the medical staff and/or the officers.
Q. Are there units where there's no box for kites?
A. I have not seen any, but I believe there might be some place where there are not boxes there.
Q. So in that case, what would the patient do when he's completed the kite?
A. He will give it to the officer and/or any of the medical staff.

Q. Is there policy on what the patient is supposed to do with the completed kite?
A. I think there's a policy on that with the general NDCS policies.
Q. But not a health care specific policy?
A. No.
Q. If the patient gives the kite to an officer, what happens next?
A. Officer, if it's medically related, he will give it to the nursing staff or the mental health staff.
Q. Who specifically is the officer supposed to give it to?
A. Any medical staff. I'm not designating any specific person, 'cause eventually it will get you to the nursing station and will sort out the process.
Q. Is the officer permitted to read the kite?
A. I do not believe so.
Q. Is there a policy saying that the officer is not to read the kite?
A. No.
Q. So how do officers know they're not supposed to read the kite?
A. I'm sure part of the training is from the STA to talk discussion about when there's a medical request, they're not supposed to read and give to medical

A. Correct.
Q. A separate skilled nursing facility record?
A. Correct.
Q. And also some behavioral health data recorded in NICAMS, correct?
A. Correct.
Q. And is the optometry record separate or is it part of the medical and mental health chart?
A. It's part the medical chart.
Q. Why is medical information kept in so many different places?
A. That's what we trying to improve. I like to have the ones -- everything in one place.
Q. Okay. But is there a reason why it's kept in so many different places?
A. I don't know. That was one of the things that I came on board, talked about it, consolidating all the records.
Q. In your view, would it be better if the records were more consolidated?
A. Absolutely.
Q. Would it be better for patient care?
A. Yes.
Q. Would it be better for patient safety?
A. Yes.

Q. Have you taken steps to bring about a consolidated medical record?
A. Yes, we have.
Q. What are those steps?
A. Well, we have, right now we trying to consolidate the medical and mental health records into one and the behavioral health site has certain sensitive documentation that counseling relies on, for example, they might be sensitive, they're still kept in the NICAM with restricted access to certain staff members.

The dental we try to consolidate into medical portion as well, we taking steps on that one. We have not been successful yet, but we are working on it. And trying to ultimately really looking at the electronic health record to consolidate all the charts. I mean, that's going to be our ideal system to look at it.

So as we talked about earlier, we have the RFI for EHR already process and we have some vendors already looking at it and we already had requested through our budget funding for EFR. And I'm hopeful that will be done in the next 12 months or so.
Q. But that request has not yet been funded?
A. No. But we have a support from some of

A. Right.
Q. Okay. At any time since you had been medical director and since you became medical director in 2017, did corrections officers ever distribute medications to patients?
A. Yes, they do.
Q. Is that still going on today?
A. Yes, they are and they all have been certified for med-aide classes.
Q. At which facilities are corrections officers distributing medications to patients?
A. We have couple of facilities at NSP, LCC, that I'm aware of.
Q. Were -- was there a time that officers were distributing medications at facilities other than NSP and LCC?
A. They might have, I'm not aware of that prior, in prior years.
Q. Okay. So are you aware of any change in the practice of officers distributing medications to patients that occurred since you've been medical director?
A. No. And these are all officers who have been certified in med-aide classes, right? We not talking about the officers who are not certified with giving

them pills, so they all have the certification.
Q. Okay. So your testimony is that all officers who distribute medication to patients have some certification?
A. Yes.
Q. Okay. Tell me about that certification.
A. The certification class is about three hours that it was provided by a health educator of the process of what needs to be done, how pills are to be distributed, how they are documented. They need to document on the M-A-R sheet and if there are any refusals, they need to document those as well.
Q. You said that training is provided by a health educator?
A. Yes.
Q. And what are those person's credentials?
A. I don't know offhand.
Q. And you said the training takes three hours?
A. Yes.
Q. Is it a one-time thing or does it have to be repeated?
A. It has to be repeated, be recertified every two years.
Q. And the requirement that officers who distribute medications be certified in this way, is that written

down anywhere?
A. Yes.
Q. Where is it written down?
A. I'm not sure where the protocol is but there is one.
Q. Now, you mentioned MARs; again, just for the record, what are MARs?
A. Medication administration records.
Q. And could you just describe briefly what they are?
A. So that's a list of, the form actually describes the medication that is given, how often they have to be given and there's a column that goes across the page, talks about who actually signed off, check off to say yes the person took the medication, if they refuse, they put the "R" for refusal and the nursing staff sign off on those.
Q. Since you became medical director in 2017, have MARs been consistently used at all NDCS facilities?
A. Yes. But we also did an audit recently that we found that they were not being used, so we took some provisions to make that change. And one of the provisions that I did discuss with the director is to move towards electronic monitoring and we just implement that process in the last couple of months.

and it reads, quote, these requests are triaged daily by health professionals per a priority system that addresses routine urgent and emergency complaints, end of quote.

Do you see that language?

A. Yes.

Q. Are LPNs included within the definition of the term health professionals in this sentence?

A. Yes.

Q. And I believe you already testified that sick call requests are sometimes triaged by LPNs?

A. Yes.

Q. Okay.

MR. FATHI: Is this a good time for break?

MR. POST: Yes.

(Whereupon, at 12:04 p.m., a luncheon recess was taken and the deposition resumed at 12:47 p.m.)

(Exhibit No. 7, marked for identification.)

Q. (BY MR. FATHI) Doctor, this morning you talked on a few occasions about policies that you're thinking of changing but you would like to revise.

Since you have been medical director, have you actually changed any written policies?

A. Yes.

Q. Which ones?
A. So one of the policies I came on board quickly was a restraint policy, where the restraint were, I felt new guidelines have changed quite a bit and so I changed the restraint policy to maximum four hours and a minimum two, definitely the person is deescalated then we should be able to take the restraint off. So then we changed that policy.

And the other one we developed more defining the levels of care for mental health. And right now we have SM --

(Court reporter interrupted for clarification.)

A. SMHU, secure mental health housing unit, and there's really the process there is current center base rather than the level of care process we have to treat people who have mental illnesses, but the SMIs were admitted to the patient, that's severe mental illness, so we chanced that policy.

We also included in our chronic care policy, the SMI was not defined to say how often do we see somebody with a severe mental illness, so my recommendation was to see everybody sees psychology every 30 days, psychiatrist at a minimum of 90 days.

We also changed some policies on the diabetics because the diabetic lab studies that needs to be

prisoners are receiving medication for mental health?
A. That's right.
Q. And the number of -- and 70 to 80 percent of prisoners are receiving mental health care of any kind?
A. That's correct.
Q. Are there different levels of mental health care within NDCS?
A. Treatment incentive based for the level of care that we talked about earlier, there's a policy that we have adopted in developing levels of care. There's acute level of care, there's chronic, intensive outpatient and outpatient.
Q. And that policy currently exists in written form?
A. Yes.
Q. And do you recall what it's -- the title or the number?
A. I don't recall the number of it, but we try to implement that policy as we speak, make some changes in the system to implement that.
Q. So is that policy currently implemented?
A. We have drafted it and we're going to admit it December 17th.
Q. Okay, so the answer to my question is no?

Q. Is it ever more than three to four per hour?
A. There might be some more for the no-shows, so they might book more people and sometimes no-shows and people don't show up so, 'cause might be in the schedule but typically only, don't see more than three or four.
Q. Tell me what kind of access the telepsych provider has to the patient's medical record?
A. They have access to NICAMS.
Q. And how does that physically, how does it occur? How does the doctor in Chicago get access to NICAMS?
A. By V, VPN system. So he go log in to the VPN and have direct access to or DOC NICAMS.
Q. Do the telepsych providers have access to the patient's paper medical record?
A. Physically since they're located at remote site, not really, no.
Q. Does the telepsych provider have access to the MARs?
A. Yes.
Q. How does that happen?
A. Electronically, since we implemented the electronic MARs, so...
Q. And when were the electronic MARs implemented?
A. Over the summer.

Q. Of 2018?
A. Yes.
Q. And are they now fully implemented at every facility?
A. Every facility except for NSP and DEC.
Q. And are patients at NSP or DEC ever seen by telepsych?
A. No, we have two part-time psychiatrists who provide coverage at NSP.
Q. So patients at NSP and DEC are never seen by telepsych?
A. Correct.
Q. Does the telepsych provider have access to the patient's kites or other requests for health care?
A. They would if they're directed to them, if they would have access to those kites.
Q. How would they have access?
A. We would electronically send it to them.
Q. How would that happen?
A. E-mail or when they have a session conducted we have somebody else on the other side with the patient and they will talk about what the visit has been, what the kites are.
Q. Other than NICAMS and the MARs, is there any other portion of the medical record that is

making that call and then call the nursing, the nurse.

Q. Call the nurse at home?

A. Well no, that would be in the facility site, we would not have an LPN left alone on the site, so there's always one nurse available.

Q. So is your testimony that every facility has at least one RN on site 24 hours a day?

A. That's correct.

Q. Is there a written policy that governs this situation, a patient having what appears to be an acute psychotic episode?

A. No, we don't, not at this time.

Q. What does the department do with patients who, whose mental health needs exceed what the department can provide, who need an inpatient level of care?

A. I think the training that we have, the psychiatrist, I believe that we can handle most of the levels of care that we can provide. But if they exceed that level of care, we do collaborate with LRC, Lincoln Regional Center, and we'll transfer the patients over there.

Q. I remember reading in some document that the department can't transfer patients to LRC; is that correct?

A. They can't not?
Q. Cannot.
A. No, that's not true, we can.
Q. Does LRC have the right to refuse them?
A. Sure.
Q. Does LRC -- does it ever happen that you want to transfer someone and LRC refuses them?
A. Not in the last two years that I know of.
Q. In the last two years, about how many NDCS patients have been transferred to LRC?
A. We have not transferred anyone. We had the inclination to actually do the collaborative work with LRC so their psychiatrist came over to see the patient at DEC and we do the treatment plan together.
Q. So no NDCS patients have been transferred to LRC since you've been medical director?
A. No, there hasn't been the need.
Q. Have any NDCS patients been transferred to any inpatient facility since you've been medical director?
A. No.
Q. Do you have any transfer options besides LRC?
A. UN -- the UNMC would be the only other option that we go with.
Q. The what?

A. They are tracked on NICAMS. They would be entering the progress notes and the data on there and that's where it would be tracked at.
Q. So if I wanted to know how many different prisoners received individual therapy last month, that report could be run on NICAMS?
A. Yes.
Q. And if I wanted to know the total number of hours of individual therapy provided, that report could be run on NICAMS?
A. We that could be provided from NICAM as well.
Q. How long has that capability existed in NICAMS?
A. I believe since last year or so, I'm not sure.
Q. Since 2017 or 20 --
A. 2017.
Q. Is the patient's access to individual therapy affected in any way if he or she is in restrictive housing?
A. No.
Q. Okay. Let's take a break.
(Whereupon at 2:38 p.m., a recess was taken and deposition resumed at 2:50 p.m.)
Q. (BY MR. FATHI) Doctor, before the break, you testified that you haven't asked for any additional positions to be allocated, to be funded by the

legislature any additional health care position; is that correct?

A. That's correct.

Q. Have you ever asked in any context for the ability to increase the compensation of health care staff?

A. Yes.

Q. Tell me about that.

A. I brought it up to our director we got compensation for health care staff, especially nursing and dentist, dental assistants, dental hygienist, tried to be comparable to the marketplace.

We had some conversation with HR who also had conversation with HR in the capitol, Jason Jackson to talk about since we have nursing staff who are uniquely qualified to do lots of different functions, you know, their skill sets are actually a lot more unique compared to what hospitalization is, so they have to be ER nurses at times, they have to be trauma nurses at times, they have to be palliative nurse at times, have to be post operative nurses at times, hospice nurses, and we end up getting some of the nurses, initially we train them and then they end up leaving us because that's partly due to the salary issues.

And I know they, a couple years ago they had a meeting with the state trying to look at the compensation for nursing and somehow the psychiatric nurses LRC look at special cases and their compensation was much more than our nurses. We we've been having this ongoing dialogue and part of the issue is the nurses have been represented by the bargaining unit, so we cannot change the union rules so that's the process we have to go through.

But, you know, the director has actually gone to legislature and talked about those issues as well to bringing it to the attention that at least we should have same playing level field so we can recruit some nurses.

We go through contract nurses obviously paying a higher rate and does not a morale boost for our staff nurses. So the things we have done, we advertise, we try to look at some of the collaboration with some of the universities, the colleges.

We recently, we actually even thought about going to international nursing. We just recruited two nurses who are going to be starting this week from Kenya, with the intention that they -- we will train them here, they will work here for a while and on contract for two years and then hopefully they

will pay back to the state with the DOC for two years. So it's been an ongoing conversation with anybody who will listen to me.

Q. Have you had any success in your efforts to increase compensation for health care staff?

A. I had some success and some failures, obviously. I was able to recruit for compensation for nurse supervisors, so that was about -- talking about a year and a half, which just happened about two months ago. But I was not able to get some compensation with director of nursing, two or three ADONs.

I continue doing, advocating for other staff too. Salaries are so low for dental hygienist, it's 12 bucks an hour. Nobody's going to work for that. And trying to tell, that's basically minimum wage anymore, so some places how do we -- provide some either compensation and/or some benefits, or some tuition reimbursement for processes, so those are being all looked into.

Q. Have you been able to secure any increased compensation for nurses?

A. No, partly because I think I'm told that since they're part of the bargaining unit, so they have to follow the union contract. And we do tell the nurses to go tell the union to fight for you, the numbers

A. Yes.
Q. What if a patient sends in a kite and describes a medical emergency, what happens?
A. That person would be seen immediately.
Q. And how do patients request to be seen immediately if they believe they have a medical emergency?
A. If, if the kite is sent to medical staff, they would go and do the assessment.
Q. Are you familiar with what's called an emergency grievance?
A. Yes.
Q. Could they also use that process?
A. Yes.
Q. What if a patient notify a correctional officer of a medical emergency?
A. And he's obligated to provide that information to the medical staff and the medical staff will follow up with that.
Q. Are you aware of any instances where a correctional officer was provided that information and did not notify medical staff?
A. Not that I am aware of.
Q. Earlier you also mentioned that you cannot train a correctional officers in diagnosis of medical

more programming in the restricted housing.
Q. So individuals in restrictive housing can and do receive group therapy?
A. Yes.
Q. Would you like to provide them more group therapy?
A. Yes, definitely.
Q. Again, as we talk about restrictive housing, do mental health and medical staff, I guess it would be mental health staff, do they do walk-through counseling sessions?
A. No.
Q. So if you've heard that phrase, what do you think it's referring to?
A. What I hear going through walk-through is door to door, they really just doing a wellness check, talking about are you taking the medication and medication effective, is there other issue we need to address, are you having any side effects, but if they need to talk about any specific counseling questions they have, that's -- they will actually be taking to patient out in a space, a private room to talk about it.
Q. Are there instances where the patient -- they're unable to take the patient out into a private room?

Deposition of DR. HARBANS DEOL

Harbans Deol

Signature of witness

STATE OF Nebraska)

: SS.

COUNTY OF Lancaster)

Subscribed and sworn to before me this

10th day of January, 2019

Konda G. Young

GENERAL NOTARY PUBLIC

DATE: November 30, 2018

GENERAL NOTARY - State of Nebraska
KONDA G. YOUNG
My Comm. Exp. November 13, 2022

DEPOSITION OF DR. HARBANS DEOL

PAGE & LINE	CHANGE	REASON FOR CHANGE
9 22	Kupkowski To Kautzky.	Correct Spelling
82 12	Change "within 14 days"	Correct after
" "	to "Dental screen within	reviewing ACA
" "	7days, and exam within	standards.
" "	30days.	
82 10	"Seven to Five".	Corrected after
82 11	" 20 to 25".	reviewing retention
		schedule 92.
82 17	"Add" retention schedule	Clarify after
" "	92 and AR 115.03".	reviewing policies
89 15	Change "No" To "AR 200.03"	Corrected
		after reviewing
		policies
91 19	Change "No" to	Corrected after
" "	"AR 200.03"	reviewing policies.
94 6	"No" to "AR 115.04	Corrected after
		reviewing policies
245 16	"NO" to "A6 and A4	Corrected after
" "	in Nursing procedures"	reviewing policies
52 16	"Console" to "Consult"	Spelling Correction
66 2	"Console" to "Consult"	Spelling Correction

DATE: November 30, 2018

DEPOSITION OF DR. HARBANS DEOL

PAGE & LINE	CHANGE	REASON FOR CHANGE
70 12	"problem" to "Program"	So Transcript reflects what I said
202 10	"fasting" to "staffing"	" " "
235 4	"O'Reagan" to "Organ".	spelling
336 6	"TAB" to "TB"	So Transcript reflects what I said.
338 17	"Laparotomy" to "Operatory"	So Transcript reflects what I said

DATE: November 30, 2018